**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ID PRECINCT**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:</th>
</tr>
</thead>
<tbody>
<tr>
<td>345526</td>
</tr>
</tbody>
</table>

**(X2) MULTIPLE CONSTRUCTION**

<table>
<thead>
<tr>
<th>A. BUILDING</th>
</tr>
</thead>
<tbody>
<tr>
<td>-----------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. WING</th>
</tr>
</thead>
</table>

**(X3) DATE SURVEY COMPLETED**

| 12/22/2011 |

**NAME OF PROVIDER OR SUPPLIER**

| THE GARDENS OF TAYLOR GLEN RET COM |

<table>
<thead>
<tr>
<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>3700 TAYLOR GLEN LANE CONCORD, NC 28027</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(X4) ID PRECINCT TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 156 SS-C</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</td>
</tr>
</tbody>
</table>

**ID PRECINCT TAG**

<table>
<thead>
<tr>
<th>PROVIDER/SUPPLIER PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 156</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-21-11</td>
</tr>
</tbody>
</table>

**A. When the deficient practice was discovered, a sign was immediately posted containing the appropriate information. (Attachment)**

**B. The sign was attached to the existing notice which is hung behind the nursing station which is centrally located on the nursing unit. The existing notice is 11 1/4" by 17 1/4" long. It is hung 37" above the floor which makes it wheelchair accessible.**

**C. The Director of Social Services will notify current residents/families of the information in a letter and during the admissions process for a new resident. (Attachment)**

**D. The Director of Social Services will notify residents of where the**

---

**LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

<table>
<thead>
<tr>
<th>Miriam Stimpson, Administrator</th>
</tr>
</thead>
</table>

**TITLE**

<table>
<thead>
<tr>
<th>Administrator</th>
</tr>
</thead>
</table>

**DATE**

| 1-19-12 |

---

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patient. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date those documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

| (X1) PROVIDER/SUPPLIER/CLA 
| IDENTIFICATION NUMBER: 346525 |

| (X2) MULTIPLE CONSTRUCTION 
| A. BUILDING: 
| B. WING: |

| (X3) DATE SURVEY COMPLETED: 12/22/2011 |

NAME OF PROVIDER OR SUPPLIER: THE GARDENS OF TAYLOR GLEN RET COMM 

STREET ADDRESS, CITY, STATE, ZIP CODE: 3700 TAYLOR GLEN LANE 
CONCORD, NC 28027

| (X4) ID PREFIX TAG |
| SUMMARY STATEMENT OF DEFICIENCIES 
| (EACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) |

| F 156 |
| Continued From page 1 |
| A description of the manner of protecting personal funds, under paragraph (c) of this section; |
A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. |
| A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. |

| ID PREFIX TAG |
| PROVIDER'S PLAN OF CORRECTION 
| (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY) |

| F 156 |
| information is located in monthly meetings. |
| E. The Director of Social Services will complete the attached audit, (Attachment C) As the information changes, the Director of Social Services will update and post the new information immediately. The Administrator will complete this audit in the absence of the Director of Social Services. |
F. The Director of Social Services will bring the results to the quarterly quality assurance meeting. The next scheduled meeting is 2-23-12. |

| (X5) COMPLETION DATE: Monthly ongoing |

FORM CMS-2567(02-69) Previous Versions Obsolete Event ID: E05F11 Facility ID: 000267 If continuation sheet Page 2 of 6
F 156 Continued From page 2
Includes a written description of the facility's policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:

Based on observation and staff interviews, the facility failed to post state agency information.
The findings included:

On 12/21/2011 at 5:26 PM, an observation revealed there was not a sign posted with information on the name, address and contact information for the Division of Health Service Regulation (DHSR) and the complaint intake unit information.

On 12/21/2011 at 5:26 PM, Administrative staff #1 stated she did not know that the information for the DHSR and Complaint intake unit was not posted. An observation of the skilled nursing area revealed that there was no posting of state agency information.

On 12/22/11 at 8:43 AM, Administrative staff #2
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(x1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER

346526

(x2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(x3) DATE SURVEY COMPLETED

12/22/2011

NAME OF PROVIDER OR SUPPLIER

THE GARDENS OF TAYLOR GLEN RET COM

STREET ADDRESS, CITY, STATE, ZIP CODE

3700 TAYLOR GLEN LANE
CONCORD, NC 28027

(x4) ID PREFIX TAG

F 156
Continued From page 3
stated the information for the state complaint unit
was only on the facility contract, signed at admission.
She further indicated that she reviewed the agency
numbers with the resident and/or responsible party
each time the resident was admitted to the skilled
nursing unit.

F 187
SS=C
483.10(g)(1) RIGHT TO SURVEY
RESULTS - READILY ACCESSIBLE
A resident has the right to examine the results of the
most recent survey of the facility conducted by
Federal or State surveyors and any plan of
correction in effect with respect to the facility.
The facility must make the results available for
examination and must post in a place readily
accessible to residents and must post a notice of
their availability.

This REQUIREMENT is not met as evidenced by:

Based on observation and staff interviews, the
facility failed to display the Survey Results
Information without residents/visitors having to ask
where the Survey Results Information was located.
The findings included:

On 12/21/2011 at 5:20 PM., survey results were
noted to be posted on a small bulletin board located
in a corner near the living room area on the skilled
nursing unit. The Bulletin Board was
approximately 4 1/2 feet from the floor. There was
not a sign identifying that the survey results were
posted there.

On 12/21/2011 at 5:20 PM., Administrative staff

F 156
The 2567 has been enlarged
for easier reading (Attachment
E)

D. The Director of Social
Services will notify current
residents/families in a letter.
(Attachment B) The Director
of Social Services will
notify the resident/family
for a new resident during
the admission process.

E. The Director of Social
Services will notify residents/ongoing
of where the information
is located in monthly
meetings.

F. The Administrator will
check the state survey
notebook once a day
weekly for one week;
Monday-Friday between
the hours of 8:00am and
5:00pm to verify
the contents are in place.
This will be done weekly
for one month and monthly
and annually as surveys occur.
Continued From page 4

#1 stated the Survey Results should be labeled so anyone would know where it was and could read it without having to ask nursing staff for the results.

On 12/22/2011 at 7:40 AM, Administrative staff #4 stated the Survey Results should be posted in the nursing area in an area that the residents can easily access including wheelchair residents. Residents and visitors should not have to ask where the results are posted.

F 167
483.35(I) FOOD PROCURE, STORE/PREPARE SERVE - SANITARY

A. Deficient practice was discovered during meal preparation and prior to being served. When the deficient practice was discovered the staff was immediately in-serviced by the Director of Dining Services
B. The Director of Dining Services in-serviced the staff. (Attachments F.18, F.371 & Agenda: F.16 meeting 2-23-12)

This REQUIREMENT is not met as evidenced by:

Based on observation and staff interviews, the facility failed to maintain sanitary conditions in the kitchen when kitchen staff failed to remove gloves, wash hands and reapply clean gloves between kitchen tasks. The findings included:

On 12/21/2011 at 11:08 AM, kitchen staff #1 was observed to remove two pieces of bread from the bread wrapper with her gloved hands, put melted butter on each piece of bread and placed it on the grill. Without removing her gloves, she placed...
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIZED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 371</td>
<td>Continued From page 5 cheese on the bread and grilled the cheese sandwich. While the sandwich was being cooked, kitchen staff #1 used the same gloved hands to move pots, pans and touched utensils to stir other food items. After she removed the sandwich from the grill with a flat utensil, she placed the sandwich on a cutting board and cut the sandwich in half, picked up the sandwich with her gloved hand and put it on a plate. During interview at 11:10 AM., kitchen staff #1 stated she always wore gloves when she prepared food and, normally, did not change her gloves during the meal preparation. She stated she removed her gloves and changed them if she changed tasks such as answering the telephone. On 12/21/2011 at 11:12 AM., Administrative staff #3 stated kitchen staff #1 should have removed her gloves, washed her hands and put on new gloves when she went from preparing the sandwich to touching the utensils and pens of food. He further stated that these were two different kitchen tasks and kitchen staff had been instructed to change gloves and wash their hands between kitchen tasks.</td>
<td>F 371</td>
<td>C. The Director of Dining Services will do a random weekly audit of x 4 weeks and monthly and annually as surveys occur. (Attachment) D. If an employee is observed with improper glove use hand washing, etc. this will be addressed as a performance issue through the progressive disciplinary process. E. The Director of Dining Services will bring the results to the Quarterly Quality Assurance meetings. The next quarterly QA meeting is scheduled for 2-23-2012.</td>
<td>Weekly x 4 weeks; then monthly and annually as surveys occur</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Id</td>
<td>Prefix Tag</td>
<td>Summary Statement of Deficiencies</td>
<td>Id</td>
<td>Prefix Tag</td>
<td>Provider's Plan of Correction</td>
<td>Completion Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----</td>
<td>------------</td>
<td>-----------------------------------</td>
<td>----</td>
<td>------------</td>
<td>--------------------------------</td>
<td>-----------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K 000</td>
<td>INITIAL COMMENTS</td>
<td>There were no Life Safety Code Deficiencies noted at time of survey on 1/1/2012.</td>
<td>K 000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Laboratory Director's or Provider/Supplier Representative's Signature: 

Title: 

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patient. (See instructions.) Except for nursing homes, the findings stated above are discontinueable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are discontinueable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.